ACTIVELIFE FAMILY CHIROPRACTIC

13299 Summerfield Way
Pickerington, OH 43147

Lisa M. Jones, DC & John D. Jones, DC

Child's Health History Form

Child's Name: _____ Age: _____ Date: _____

Address: _____ City/State/Zip: _____

Phone: _____ DOB: _____ SSN: _____

Mother's Name: _____ Father's Name: _____

Whom may we thank for referring you? _____

Health Profile

If your child has no symptoms or complaints, and is here for wellness services, please check ( )

If your child has symptoms/complaints, please describe below:

_____

_____

_____

How often does the symptom/complaint occur? ( ) Occasionally ( ) Frequently ( ) Constantly

Since the problem started, is it: ( ) About the same ( ) Getting Better ( ) Getting Worse

Have they ever had this symptom/complaint before? ( ) Yes ( ) No

What caused the current complaints? _____

How long have the current complaints been present? _____

Does anything make it worse? _____

Does anything make it better? _____

Does it interfere with: ( ) School ( ) Sleep ( ) Walking ( ) Sitting ( ) Hobbies ( ) Other (list below)

_____

Other doctors seen for this problem: Chiropractor: _____

Medical doctor: _____ Other: _____

List medications the child is taking or surgeries the child has had:

_____

_____

_____

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List any allergies to medications: _____

Child's Height: _____ Weight: _____

Daily we experience physical, chemical, and emotional stresses that can accumulate and result in loss of health. Most times the effects are gradual and begin very early in life. Answering these questions will give us information that will allow us to better assess the challenges to your child's health.

Pregnancy:

Were there any complications to the pregnancy? _____

Was mom on any medications, prescriptions, or over the counter meds? ( ) yes ( ) no

If yes, explain: _____

Did mom or dad smoke during pregnancy? ( ) yes ( ) no If yes, who? _____

If yes, are there still smokers in the home? _____

Was the bay ever in the Breech position? ( ) yes ( ) no

How many ultrasounds were performed? _____

Birth and Delivery:

Where was the baby born? ( ) Home ( ) Hospital ( ) Birthing Center ( ) Other: _____

Was the delivery: ( ) Vaginal ( ) C-section

Was ocytocin/pitocin used? ( ) yes ( ) no

Was an epidural administered? ( ) yes ( ) no

Were there any complications with the birth? _____

Infancy:

Was the infant vaccinated? ( ) yes ( ) no

Was your child breast fed? ( ) yes ( ) no If yes, for how long? _____ wks/mos/yrs

Was there any prolonged use of medicines or an inhaler? ( ) yes ( ) no

If yes, which? _____

Did the infant suffer traumas such as a serious fall or car accident? ( ) yes ( ) no

Explain: _____

Has the infant been under any chiropractic care? ( ) yes ( ) no

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Childhood Years

Did the child have any childhood illnesses? ( ) yes ( ) no Explain: _____

_____

Does the child play youth sports: ( ) yes ( ) no Which sports: _____

How many hours per week? _____ Age child began sport? _____

Has the child had any surgeries? ( ) yes ( ) no Explain: _____

Has the child had any falls or been involved in any car accidents ( ) yes ( ) no Explain: _____

_____

_____

Has there been any use of meds, including antibiotics? ( ) yes ( ) no Explain: _____

_____

Has the child suffered emotional trauma? ( ) yes ( ) no Explain: _____

_____

What is the average number of hours of TV/Computer/Elec games per week? _____ hrs.

Does your child have any difficulty sleeping, night terrors, or sleepwalking? _____

_____

Did your child go to daycare? ( ) yes ( ) no If so, from what age? _____

Please give us any other health information you feel would be helpful: _____

_____

The statements made on this form are accurate to the best of my recollection and I request and give consent to this office to chiropractically examine and care for my child.

Parent's signature: _____ Date: _____

Parent's printed name: _____